Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SOLUTIONS, LLC 8241 GRAND AVENUE RIVER GROVE IL 60171	MFDR Tracking #: M4-04-1093-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO BOX # 54	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Reimbursed incorrect provider Authorization was received by us."

Principal Documentation:

1. DWC060
2. Medical Bill(s)
3. EOB(s)
4. Medical Reports
5. Total Amount Sought $5,359.12

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "First, it is this carrier's position that the requester may not bill for services or supplies as the requester is not one of the entities that may bill for services to injured workers." "Secondly, this carrier received a bill for the supplies in question from the doctor's office[1], B&B Pain Management, and processed that bill. Therefore, this is a duplicate charge for supplies…" "Further, it is this carrier's position that the cost of doing business is included in a vendor's charge for the supplies and NO additional reimbursement is due for 'shipping and handling'." "Therefore, no reimbursement is due to the requester because the requester is not a qualified provider and the same supplies were included in a bill from another provider."

Principal Documentation:

1. DWC060

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
4/28/2003	19, N3, YO,	codes E1399 (X2), E1399-RR, 99002	$5,359.12	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. These services were denied by the Respondent with reason code "19-The provider billed for a procedure which is either subsumed, or bundled, into payment for another services on this date, or it is excluded from the fee schedule all together; N3-A reduction was made because a different provider has billed for the exact services on a previous bill; and YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed."
2. The Division has determined that good cause exists to dismiss this request based on: the Requestor no longer operates an active practice at the above address. The Division was unable to contact the Requestor via telephone attempts; the listed phone number(s) have been disconnected. The health care provider has not provided a current, correct address or contact information in accordance with 28 Tx. Admin. Code section 102.4 (d) and/or 102.5.
3. For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §408.021, §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.305, §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		July 26, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.